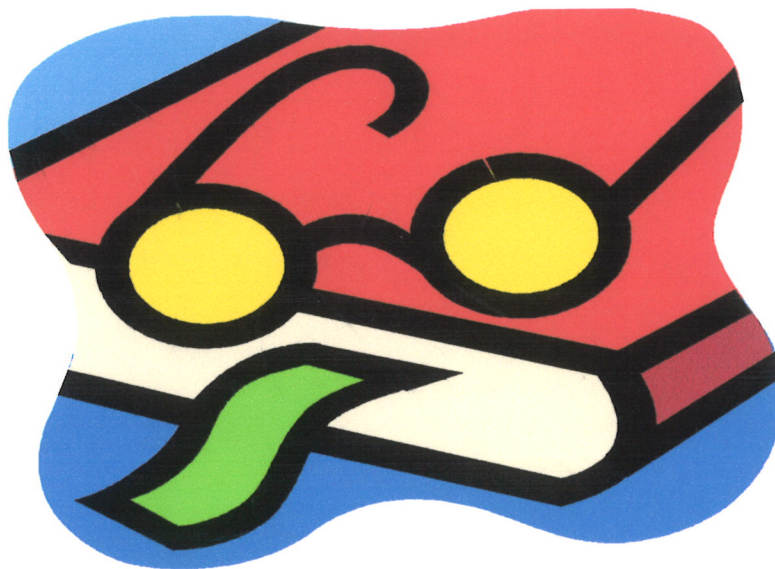


MEDICAID AND LONG TERM CARE



**MICHIGAN STATE LONG TERM CARE
OMBUDSMAN PROGRAM**

This booklet is provided by the **Michigan State Long Term Care Ombudsman Program**. The purpose of the program is to improve the quality of care and quality of life for the 100,000 individuals who live in Michigan's nursing homes, adult foster care homes, or homes for the aged. The program can be reached toll-free

1-866-485-9393

This project was initiated by Brad Geller, who acknowledges invaluable assistance from Kathryn Cook and Sharon Terry, former DHS staff; Kate Restrick, University of Michigan; Susan Meier, member of the Elder Law and Disability Rights Section of the State Bar; and Sarah Slocum, Michigan State Long Term Care Ombudsman.

Medicaid and Long Term Care

Introduction

We all know long term care in a nursing home or other setting is very expensive. We worry whether we can afford it should we need such care now or in the future.

There are government programs to help pay these costs. Whether you or a loved one is eligible, and how much assistance is available, are complicated questions.

This pamphlet contains basic information to get you started. It contains questions and answers, copies of forms to help you know what to expect, and lists of agencies to contact. The information is not authoritative, and the rules can change often.

If you have questions after reading the pamphlet, you can contact –

Your local office of the **Michigan Department of Human Services**. A list of offices and telephone numbers is located in Appendix N of this booklet, or

The **Medicare and Medicaid Assistance Program**, toll-free at **1-800-803-7174**, or

A **lawyer** familiar with the Medicaid program.

Medicaid and Medicare

What is Medicaid?

Medicaid is a state and federally funded program designed to pay for many health care needs of individuals who are determined eligible. Medicaid eligibility is determined by the Michigan Department of Human Services.

What factors determine if I am eligible for Medicaid?

Eligibility depends on your age or disability, your income, the value of certain *assets* you own, and the amount of your long term care expenses. In some circumstances, whether you are single or married will affect your eligibility.

Having other medical insurance will not affect your eligibility for Medicaid.

What is an asset?

An asset is anything you own. For Medicaid eligibility, some of your assets are not counted.

How is Medicaid different from Medicare?

Unlike Medicaid, Medicare is funded entirely by the federal government and individual premiums. Medicare is run by the Social Security Administration. Eligibility for Medicare is not based on your income or the assets you own.

What factors determine my eligibility for Medicare?

To be eligible for Medicare you must meet one of the following qualifications:

- * Age 65 or older
- * End-stage renal disease
- * Lou Gehrig's Disease
- * Social Security Disability payments for at least two years

Does Medicare cover any of the costs of long term care?

Yes. But Medicare only covers skilled care in a nursing home for a short time, and only after a hospital stay of at least 3 days. Medicare can pay all nursing home costs for your first 20 days in the nursing home, and part of the cost for days 21 - 100, as long as you continue to need skilled care. Skilled care includes services such as intravenous injections or physical therapy.

Under certain circumstances, Medicare covers home health care.

Is it possible to have both Medicare and Medicaid?

Yes. Many people have both Medicare and Medicaid.

Does Medicaid cover any of the costs of long term care?

Yes, as long as you are financially eligible and you need the type of care available in a nursing home.

Is there a time limit on how long I can receive Medicaid benefits for long term care?

No. But your financial eligibility will be reviewed by the Department of Human Services once a year.

Estate Recovery

If I receive Medicaid, will the State of Michigan take my house when I die?

Estate recovery is a process by which the state is paid back upon the death of an individual receiving Medicaid-paid long term care services. Michigan has a law establishing estate recovery, but as of February, 2009 does not yet have approval from the federal government to begin the program.

When it is approved, the policy might apply to individuals who began to receive nursing home care or waiver services after September 30, 2007.

If I am married, will the State take my home at the time of my death?

No, not if your spouse is living in the home. And there will likely be other circumstances when the State will not take your house. The specifics of Michigan's program are still under review by the federal government.

If I need to repay Medicaid, will I owe the full value of my house?

Likely no. Under the proposed program, the state will look at the average price of a house in your county at the time of your death. Your estate could often keep an amount equal to half that value.

How can I get up-to-date information about estate recovery?

You can call the Medicare-Medicaid Assistance Program at 1-800-803-7174.

Cost of Care

If I am in a nursing home and eligible for Medicaid, will Medicaid pay the total cost of care?

The yearly cost of a nursing home bed under Medicaid is about \$47,000. If you are not married, you will pay most of your income toward the cost of nursing home care. Medicaid will pay the balance.

Do the same rules apply if I am married, and my husband or wife does not live in a nursing home?

No. There are different rules for a married couple. These rules will be explained later in the booklet.

Preparing To Apply

If I am married, and I enter a nursing home before I have Medicaid, what steps I should take?

One important step is to call and ask the Michigan Department of Human Services to send you an *Assets Declaration*. A copy of the form is Appendix A in this pamphlet.

On the form, you list the value of bank accounts and other assets you and your husband or wife own (except for your home, home furnishings, clothing, and jewelry) on the day you enter the nursing home (or enter the hospital if a nursing home stay follows).

You can mail or bring this completed form to the local Department of Human Services, so the caseworker can do an *Initial Asset Assessment*.

Are there other steps?

Whether or not you are married, gather and organize -

- * Current bank statements and brokerage statements
- * Bank statements for the past several months
- * Pension statements, showing your current benefits
- * Most recent benefit letter from Social Security showing your monthly benefit
- * Any other documents that show the value of your assets and income

Are there any other records I need to gather?

Yes. Make sure you obtain bank statements or stock brokerage statements about accounts you have closed and property you have sold or given away within the last five years

Gather all medical bills that you have not paid yet, including nursing home bills.

If you have life insurance, ask the company to send you proof of the policy's face value and cash surrender value.

Care Outside a Nursing Home

Are services available if I need the type of care in a nursing home, but I want to remain at home?

Yes. If you are financially eligible and you need the type of care available in a nursing home, Medicaid may be able to pay for some services you

need through the *waiver program* (also known as *MI CHOICE* or *home and community based care*), or through *Home Help Services*.

In addition, if you are age 60 or older, there are services not funded through Medicaid. Your Area Agency on Aging provides care management, and can arrange or direct you to home-delivered meals and other home-related services. A list of Area Agencies on Aging is included as Appendix L of this pamphlet.

Most counties also have a council on aging or commission on aging you can contact for information.

What types of services are available under the waiver program?

Services include having someone do chores and house cleaning, home modifications, home delivered meals, transportation, and private duty nursing. Help with personal care can also be provided to waiver participants.

Whom should I call about the waiver program?

Contact the waiver agent in your area to find out details about eligibility, benefits, and any waiting list for services. A geographical list of waiver agents is included in Appendix M.

What services are available under the Home Help Services Program?

If you are a Medicaid recipient, the Department of Human Services may be able to pay someone to help you with housework, laundry, grocery shopping, meal preparation and personal care. You can choose a friend or relative to provide the services and care, or you can choose a business. This program cannot pay for transportation, or for any services provided by a spouse.

The Department of Human Services may also be able to pay for bath transfer benches, special eating utensils, lift chairs, bed tables and other items not paid by Medicaid or other insurance, so you may remain more independent.

How do I apply for Home Help Services?

When you apply for Medicaid, tell your caseworker you want Home Help. If you are already enrolled in Medicaid, call your Department of Human Services office and ask for an *adult services worker*. A caseworker will mail you a brief application along with a form for your doctor to fill out and sign. Your doctor indicates on the form that you need the kind of assistance provided by the program.

After you mail both forms back to the Department, someone will contact you to make an appointment. The worker will come to your home to determine the tasks you need and the amount of time per week for which the Department can pay.

Applying for Medicaid

When should I apply for Medicaid for long term care?

You should apply when you need the type of care available at a nursing home and you will soon not be able to afford the full cost of care.

If you apply and you are determined not to be eligible, you can apply again at a later date.

How do I apply for Medicaid?

You first complete a *Medicaid Application*. A copy of the application is Appendix B to this booklet.

You can get an application by calling the county office of the Michigan Department of Human Services, at the telephone number listed in Appendix P of this booklet.

If I am married, do I use the same form?

Yes. But you must also complete an *Assets Declaration*, if you have not already done so. See Appendix A.

What if I receive Supplemental Security Income?

If you receive Supplemental Security Income (SSI), you are automatically eligible for Medicaid. You need not complete an application.

You are eligible from the first day of the month in which you receive your first SSI check.

Can someone fill out the Medicaid application for me, with information he or she obtains?

Yes. Another person - such as a family member - can fill out and sign the application for you. You can also have a non-family member fill out the application if you give that person written permission to do so.

What information will I need to complete the application?

You are asked for information such as -

- * Your income, and the sources of income
- * The value of your house, and the amount of any mortgages
- * The amount you have in the bank, in stocks, in retirement accounts and the value of other assets you own
- * The value of any life insurance you own
- * The value of a pre-paid funeral contract

What if I am married?

You will then need to include your husband or wife's income, and the value of his or her bank account and other assets.

What do I do when the application is completed?

You, or someone on your behalf, must drop off or mail the Application (or the Application and Assets Declaration if you are married) to the local Department of Human Services office. (If you have already sent in the Assets Declaration, you need not send another copy.)

What will happen next?

You will receive a *Verification Checklist* from a caseworker at the Department of Human Services. See Appendix C. For each of the items checked off, send in a photocopy of the document requested. (Do not send the original document.)

You have 10 days to send in this information. If you need more time, call the caseworker and request an extension. The caseworker's name and telephone number are on the checklist letter.

What are the likely documents for which I will be asked?

- * A copy of your driver's license or state-issued ID card, to prove your identity.
- * A copy of your birth certificate, and Social Security card or Medicare card.
- * Documents showing your current monthly income, such as a Social Security statement and pension statement.
- * Your latest monthly bank statement for each account on which your name appears (even if there are other names on the account). You can show this information on a *Verification of Assets* form. Appendix D.

- * Proof of the current value of stocks, annuities and retirement accounts
- * A copy of life insurance policies or a *Life Insurance Verification* form. See Appendix E.

What if I have unpaid medical bills?

Depending on your assets and income during the three months before you apply, you may be eligible to have some or all of these medical bills paid.

If you indicate on your Application you have unpaid medical bills for services you received during the past three months, you will be asked to complete a *Retroactive Application*. See Appendix F.

If I am married, do I also provide documents indicated on the Checklist about my wife or husband's income, bank accounts and other assets?

Yes. And you will be asked for copies of bills for household expenses, such as utilities, rent or mortgage, property taxes and property insurance.

What if I am under age 65 and have a disability?

You must have a document showing you are receiving Social Security disability payments (known as RSDI).

Even if you don't receive these payments, you can give the caseworker evidence showing you are disabled. The Department will conduct a review to determine if you are eligible for Medicaid based on your disability.

Determining Eligibility

How does the Department of Human Services determine if I am eligible for Medicaid?

The caseworker will determine the value of your *countable assets*. If you are not married and your countable assets are greater than \$2,000, you are not eligible for Medicaid now.

What possessions of mine are countable assets?

Among countable assets are the following -

- * All cash, bank and credit union accounts, including certificates of deposit
- *
- * Individual retirement accounts, stocks and mutual funds
- * The cash surrender value of life insurance, to the extent the face value exceeds a total of \$1,500 for all policies you own
- * A vacation home, a second car, or a boat (minus any loans outstanding on these items)

How does the Department value a bank account I own jointly with my son or daughter?

The Department of Human Services will consider all money in the bank or credit union account, in certificates of deposit or savings bonds belongs only to you even though the account is in more than one name.

However, if you can provide evidence your children contributed money to the account, that amount will not be counted as belonging to you.

How does the Department value assets other than a bank account I own with someone other than my spouse?

Each owner of assets including real estate and stock is considered to own an equal share, unless you show ownership is different from that.

What assets can I own, and still be eligible?

Some of these are -

- * Your home (except if you are single and your equity exceeds \$500,000), and all attached acreage
- * Clothing, jewelry, and home furnishings
- * One car

What else can I own, and still be eligible?

For instance -

- * Life insurance with a face value totaling \$1,500 or less
- * A prepaid funeral arrangement (up to \$11,072) which you cannot cancel, and burial spaces for you and your family
- * An amount you borrow from the bank if the money is kept in a separate savings or checking account
- * Real estate or other asset which you are unable to sell, after having tried to sell for a month or longer

If I am not married, what is the value of countable assets I can own and still be eligible?

All your countable assets, when the value is added up, must not be more than \$2,000.

What if I am married?

If you are married, and both you and your spouse are in a nursing home, each of you can have countable assets worth no more than \$2,000.

If you are married, but only you need long term care, different rules apply. You will need to complete an Assets Declaration, referred to on page 6, listing property you and your spouse own, either individually or jointly.

What will the Department of Human Services do with the information?

After verifying the total value of countable assets shown on the Assets Declaration or Application, the caseworker will determine a ***Protected Spousal Amount***. That is the maximum amount the spouse still living at home is allowed to keep for the nursing home spouse to remain eligible for Medicaid.

In 2009, if the total value of a couple's countable assets is \$43,824 or less, the Protected Spousal Amount is \$21,912. These amounts increase each year.

What if the total value is greater than \$43,812?

If the total value is between \$43,812 and \$219,120, the Protected Spousal Amount is one half the total value.

If the total value is greater than \$219, 120, the Protected Spousal Amount is \$109,560.

What are some examples?

Allan and Susan Jones have combined countable assets totaling \$32,000. The Protected Spousal Amount for them will be \$21,912 the minimum amount.

Jenny and Steven Jackson have combined countable assets totaling \$160,000. The Protected Spousal amount for then will be one-half of \$160,000, or \$80,000.

Sarah and John Smith have combined countable assets totaling \$350,000. The Protected Spousal Amount for them will be \$109,560. This is the maximum amount allowed, unless raised through a court proceeding.

Is my home a countable asset in determining the Protected Spousal Amount?

Your home is not a countable asset if you own it, or if you own it with your spouse. However, it is a countable asset if the home is owned by a trust at the time you complete the Assets Declaration.

What does the Department do once the Protected Spousal Amount is determined?

The Department will subtract the Protected Spousal Amount from the value of the combined countable assets on the date the value of the assets is verified by the caseworker. If the result is \$2,000 or less, you are *asset eligible*.

Income Eligibility

What is the next step?

If you are asset eligible, the caseworker next determines if you are *income eligible*.

If you are income eligible, the caseworker will determine the amount of your income to be paid to the nursing home.

How does the Department of Human Services decide if I am income eligible?

First, the Department adds up all your monthly income, such as Social Security, pension, and Veteran's benefits.

Second, certain of your expenses are subtracted from your income, such as -

- * Your *personal needs allowance* (also known as patient allowance) of \$60 per month
- * Health insurance premiums you pay for Medicare and for any type of private health insurance
- * If you are married, possibly an amount for living expenses for your spouse at home, depending on the amount of your spouse's income

Third, the Department looks at your nursing home expenses. If your nursing home bill is higher than your income after your expenses are subtracted, you are eligible for Medicaid.

Can some of my income go to my spouse at home to help her or him with living expenses?

Usually, yes.

How is the amount of my income that can go to my spouse determined?

The amount depends on a complicated formula which includes whether your spouse has either children under age 21 or other dependents at home and -

- * Your spouse's income
- * Your spouse's health insurance premiums
- * Monthly rent, utility costs, mortgage and home equity loan payments
- * Monthly cooperative and condominium fees
- * Property taxes and homeowners insurance

After these calculations, how much will my spouse at home have for his or her needs?

The lowest amount your spouse can have is the smaller of your combined monthly incomes or \$1750 per month. (This amount will increase to \$1821 in Spring, 2009.)

Depending on housing expenses, the most your spouse can have is the higher of your spouse's monthly income alone or \$2739 per month.

These dollar figures are updated each year.

Can my husband or wife receive more than \$2,739 per month from me?

Yes. This amount can be increased through a court proceeding if your income exceeds \$2,739 per month. If you wish to go to court, it will be helpful to see a lawyer familiar with the Medicaid program.

How long does the Department of Human Service have to make a decision on eligibility?

The Department of Human Services is supposed to determine if you are eligible for Medicaid within 45 days after the Department receives your application. The Department has 90 days if a disability determination is required.

Will I receive anything from the caseworker while I wait for the decision on my eligibility?

If the caseworker can not make a decision within a week, you should receive a *Tentative Patient Pay Notice*. See Appendix G. This document shows an estimated *patient pay amount*.

What is a patient pay amount?

A patient pay amount is the portion of your monthly income you must pay toward your nursing home costs.

If You Are Determined Eligible

What if the Department of Human Services determines I am eligible for Medicaid?

You will receive a *Medicaid Program Eligibility Notice* stating that you are eligible, the date of your eligibility, and the amount of your patient pay amount. See Appendix H of this booklet.

In some circumstances, your patient pay amount will be zero.

The nursing home collects the patient pay amount from you, and bills Medicaid for the balance of the cost of your care.

Will I have any money to spend as I wish?

Yes. You will have a *personal needs allowance* of \$60 per month.

On what date will I be eligible?

If you are eligible for Medicaid, eligibility begins on the first day of the month during which your application is received by the Department of Human Services.

What if I have sent in a Retroactive Application?

Eligibility may begin up to three months earlier if you have unpaid medical bills for services received during this time. These bills might make you income eligible for one or more of these three months.

What if I am married?

Along with the Eligibility Notice, you will also receive an *Initial Asset Assessment Notice*. See Appendix I.

The form shows you three things:

- 1) The initial assessment (the total value of the countable assets held by you and your husband or wife)
- 2) A list of the countable assets and the value of each
- 3) The Protected Spousal Amount (the value of the countable assets your spouse can keep, and you still be eligible for Medicaid)

Are there other forms I will receive if I am married?

Yes. You will receive a third form, known as an *Asset Transfer Notice*. See Appendix J. This shows the value of assets that are in your name now (or in joint names), which must be transferred to your husband or wife's name or to your child who is blind or disabled.

You have one year to complete these transfers. If you do not transfer these assets within one year, you will no longer be eligible to receive Medicaid.

At that point, is there anything else I need to send to the Department of Human Services?

You may be asked to complete an *Intent to Contribute Income* form. See Appendix K. On this form, you agree or disagree to make part of your income available to your spouse at home. (If you don't agree, this income will go to the nursing home as an increased patient pay amount instead of to your spouse.)

You should return this form to the Department of Human Services within 10 days after the Department mails it to you.

Once I am found eligible for Medicaid, will my spouse at home have to contribute any of her or his income toward my care?

No.

If You Are Determined Ineligible

What if the Department decides I am ineligible for Medicaid?

Whether you are single or married, you will receive a *Medical Program Eligibility Notice*. See Appendix H. The form states why you have been denied.

If you disagree with the reason or reasons for your denial, you can contact the caseworker to see if an error has been made. The caseworker's name and telephone number are on the Eligibility Notice.

What if I still believe an error has been made?

Within 90 days of getting the Medical Program Eligibility Notice, you can ask for a hearing. To do so, you complete and send to the Department the *Request for Hearing* (which is on the second page of the Medical Eligibility Notice).

If the Medical Program Eligibility Notice states my application was denied because I have excess assets, what can I do?

You can spend some of the money you have in the bank. You can sell a boat, a second car, or vacation property for full value, and then spend that money on those items that are not countable in determining Medicaid eligibility.

For instance, you can -

- * Pay bills that are due or past due, including utility bills, taxes, and medical bills for you and your husband or wife
- * Buy clothing and other personal items
- * Pay the costs of nursing home care
- * Pay for remodeling or repairs to your home

- * Pay for a funeral if the money you pay is non-refundable. The cost of the funeral cannot exceed \$11,072
- * Purchase a casket and burial plots for you and your immediate family

Should I keep records of these expenses?

Yes. Keep all credit card statements, bank statements, receipts, and contracts showing what you bought and how much you paid. You may be asked by the Department of Human Services to show how you spent this money.

Can I have a trust created and put money in the trust?

There are certain types of *trusts* that can be created if you are married or disabled. A trust is a legal entity with one or more trustees and a beneficiary. For further information, you should seek the advice of a lawyer familiar with the Medicaid program.

Can I give money or property away?

With certain exceptions, you will likely suffer a penalty if you give assets away in order to become eligible for Medicaid, and the assets are not returned to you.

The penalty will disqualify you from receiving Medicaid for nursing home care and waiver services for a period of time after you otherwise qualify,

The length of time you are disqualified depends on the value of what you have given away. For 2008, you will be disqualified one month for every \$6,191 you have given away.

To whom can I give away assets without a penalty?

You can transfer money and property to your husband or wife, and to your child - if your child is blind or has a disability.

You can give your home to a child under age 21, or child age 21 or older who provided care to you for two or more years before you entered the nursing home.

If I receive notice I do not qualify for Medicaid, when should I reapply for Medicaid?

You should reapply when you have spent your excess assets. If you are single, your countable assets must total no more than \$2,000.

When I am not eligible for Medicaid, how is the amount I pay the nursing home determined?

The amount you pay as a private-pay resident is determined by the contract between you (or someone with legal control of your money) and the nursing home.

Some homes charge as much as \$7,500 per month.

Once You Are Determined Eligible

Unless questions arise, when will I next hear from the Department of Human Services?

Once a year, you will receive a new application that you must complete. This process is known as *Redetermination*.

Do I need to do anything during the first year I am eligible?

If you are married, you have one year to remove your name from countable assets you own or jointly own, such as a second car, a boat, stock, or vacation property.

You do not need to sell them. You can transfer the asset, your interest in the asset, or the value of the asset to your husband, wife, blind child or disabled child.

What about other assets?

Your total amount of countable assets, including a bank account or joint bank account, must be valued at \$2,000 or less on at least one day during each month.

Can I give my wife or husband access to the bank account?

Yes. You can have a joint account with only your money in it, or you can sign a *durable power of attorney for finances* to allow your spouse to withdraw money for you.

What about the house?

You can speak with a lawyer about whether to put the house and other non-countable assets in the community spouse's name alone.

What if I move from the nursing home?

If you move from a nursing home to a house, apartment, or other living arrangement, you may still be eligible for certain services paid through Medicaid.

Make sure to telephone your caseworker at the Department of Human Services to report your new address. If you get a recording, leave your name, your new address and the date you left the nursing home.

Long Term Care Connections, MI-Choice Waiver Agents and Centers for Independent Living may also be able to provide help to you during this transition period.

The Future

If I remain in the nursing home, will there be any further paperwork to complete?

Yes. Once a year you will be asked to complete a new Medicaid Application, a process known as *Redetermination*.

At that time, you will need to provide proof of your assets, income, and expenses, such as medical insurance premiums.

What if I am married?

You will be asked for documents proving -

- * Your income
- * Your assets
- * Income of your spouse
- * Home expenses of your spouse
- * Proper transfer of assets, so your countable assets now total \$2,000 or less

How can I pay for medical needs not covered by Medicare or Medicaid?

For necessary medical care not covered by Medicaid, including services provided by a dentist, podiatrist, chiropractor or hearing aid dealer, you can use money you would otherwise pay to the nursing home. The nursing home will lower your patient pay amount for that month.

More Information

What if I have further questions now or in the future?

If you have questions about Medicaid and long term care, you can contact the following resources:

- * Michigan Department of Human Services. A list of local offices and telephone numbers can be found in Appendix P of this booklet.
- * Medicare and Medicaid Assistance Program can be called toll-free. 1-800-803-7174
- * Michigan MI Choice Waiver Agents are listed in Appendix M.
- * Michigan Long Term Care Connections are listed in Appendix N.
- * Area Agencies on Aging are listed in Appendix L.
- * Michigan Long Term Care Ombudsman Program can be called toll-free. 1-866-485-9393
- * A lawyer familiar with the Medicaid program.

ASSETS DECLARATION
PATIENT AND SPOUSE
Michigan Department of Human Services

FOR OFFICE USE ONLY				
Grantee Name				
Grantee Client ID				
Case Number				
County	District	Section	Unit	Specialist

PLEASE PRINT

Patient's Name (First, Middle, Last)		Phone No. of Nursing Home	Spouse's Name (First, Middle, Last)		Spouse's Phone Number
Address of Nursing Home (Number, Street, Rural Route)			Spouse's Address (Number, Street, Rural Route)		
City	State	Zip Code	City	State	Zip Code
Patient's Birthdate (Mo/Day/Yr)		Patient's Social Security Number	Spouse's Birthdate (Mo/Day/Yr)		Spouse's Social Security No. (Optional)

This form asks questions about the property or assets owned by you and/or your spouse. This information is needed to determine your eligibility for Medicaid and the amount of assets that can be protected for the benefit of your spouse. Answer the following questions by providing information about all assets owned by you and/or your spouse as of _____. Include assets you or your spouse own jointly with family or other persons.

ASSETS

1. Does anyone in your household have any assets (include assets held jointly)?

☐ Yes

▶ Check all types of assets your household has and complete the table

☐ No

- | | | |
|---|---|---|
| <input type="checkbox"/> Checking/draft accounts | <input type="checkbox"/> Money market accounts | <input type="checkbox"/> Savings/share accounts |
| <input type="checkbox"/> Certificates of Deposit (CD) | <input type="checkbox"/> Christmas club accounts | <input type="checkbox"/> Patient trust fund |
| <input type="checkbox"/> Cash on hand or in safe deposit | <input type="checkbox"/> Savings, bonds, stocks or mutual funds | <input type="checkbox"/> IRS, KEOGH, 401K or Deferred Compensation account(s) |
| <input type="checkbox"/> Trust or annuities | <input type="checkbox"/> Land contract, mortgage or other notes payable to household member | <input type="checkbox"/> Real estate (not including place you live) |
| <input type="checkbox"/> Life estate | <input type="checkbox"/> Burial plot(s), casket, etc. | <input type="checkbox"/> Tools and equipment |
| <input type="checkbox"/> Life insurance | <input type="checkbox"/> Other Assets _____ | <input type="checkbox"/> livestock or crops |
| <input type="checkbox"/> Burial trust/funeral contract(s) | | |

Owner(s) of asset(s)	Type(s) of asset(s)	Balance, amount or value	Name and address (bank, insurance company, etc.)	Account/policy number, etc.

AUTHORITY: 42 CFR Part 435.
COMPLETION: Voluntary.
PENALTY: No Medicaid.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

ASSETS

2 Does anyone in your household have any vehicles?

☐ Yes

▶ Check all types of assets your household has and complete the table

☐ No

☐ Car ☐ Truck ☐ Boat ☐ Campers / trailers ☐ Motorcycles ☐ RV ☐ Other Vehicles

Owner(s) (As shown on vehicle title or registration)	Year	Make / Model	Amount owed

3. Has anyone in your household:

• sold or given away property, land, vehicles, stock, bonds, savings, cash, checking, income, etc., closed any accounts or removed or added a name on any asset within 60 months?	<input type="checkbox"/> Yes ▶ Who: <input type="checkbox"/> No
• filed a pending lawsuit which may bring money, property, etc.?	<input type="checkbox"/> Yes ▶ Who: <input type="checkbox"/> No
• received a one-time cash payment (such as worker's compensation, lottery winnings, insurance settlement, lawsuit award, etc.) within the last 60 months?	<input type="checkbox"/> Yes ▶ Who: <input type="checkbox"/> No
• or has anyone acting for any household member, ever put any money, lawsuit settlement, income or assets in a trust, annuity or similar legal device?	<input type="checkbox"/> Yes ▶ Who: <input type="checkbox"/> No

AFFIDAVIT

I swear or affirm that all the information that I have written on this form or told to a specialist is true. I understand that I can be prosecuted for perjury if I have intentionally given false information. I also know that I may be asked to show proof of any information I have given. I also know that if I have intentionally left out any information or if I have given false information, which causes me to receive assistance I am not entitled to or more assistance than I am entitled to, I can be prosecuted for fraud.

Signature (Patient or Representative)		Date (Month, Day, Year)	
Two Witnesses Only If Signed by Mark X	Signature of First Witness	Signature of Second Witness	
NOTE: If you signed this application on behalf of someone else, complete the information below.			
Name (First, Middle, Last)	Phone Number	Relationship to patient	
Street Address	City	State	Zip Code

MEDICAID APPLICATION
Patient of Nursing Facility
 State of Michigan
 Department of Human Services

HELP IS AVAILABLE

FOR OFFICE USE ONLY				
Grantee Name				
Grantee Client ID				
Case Number				
County	District	Section	Unit	Specialist

THE DEPARTMENT OF HUMAN SERVICES MUST HELP ALL PERSONS FILL OUT THE APPLICATION, WHEN REQUESTED. IF YOU NEED HELP, PLEASE CALL OR VISIT YOUR SPECIALIST OR THE OFFICE NAMED BELOW. IF YOU NEED AN INTERPRETER, THE DEPARTMENT WILL PROVIDE ONE FREE OF CHARGE OR YOU MAY USE ONE OF YOUR CHOICE. IF YOU ARE REFUSED HELP IN FILLING OUT THE APPLICATION, YOU MAY CALL (517) 373-0707.

Do you need the Department to provide an interpreter to help you at the interview? () Yes () No

If yes, what language? _____

EL DEPARTAMENTO DE HUMAN SERVICES DEBE AYUDAR A TODAS LAS PERSONAS A COMPLETAR LA APLICACION CUANDO ASI LO PIDEN. SI UD. NECESITA AYUDA, POR FAVOR LLAME O VISITE A SU ESPECIALIST O LA OFICINA QUE SE MENCIONA ABAJO. SI NECESITA UN INTERPRETE, EL DEPARTMETO LE PROPORCIONARA UNO GRATIS O UD. PUEDE USAR UNO DE SU ELECCION. SI UD. ES NEGADO AYUDAPARA COMPLETAR LA APLICACION, PUEDE LLAMAR AL (517) 373-0707.

¿Necesita que el Departamento proporcione un interprete para que le ayude en la entrevista? () si () no
 Si dice que si, ¿en que idioma?

يجب على هيئة الاستقلال العائلي لولاية ميشيغان أن يساعد كافة الأشخاص لملء الاستمارات عندما يطلب منهم ذلك. إذا كنت تحتاج إلى مساعدة، يرجى الاتصال أو زيارة الإخصائي الذي ينظر بقضيتك أو المكتب المبين أسمه أدناه. وإذا كنت تحتاج إلى مترجم، ستقوم الدائرة بتوفير مترجم لك بدون مقابل، أو باستطاعتك اختيار من ترغب. وإن تم رفض مساعدتك بملء الطلب، يمكنك الاتصال بالهيئة على الرقم ٣٧٣-٠٧٠٧ (٥١٧).

هل تريد من الدائرة أن توفر لك مترجماً كي يساعدك أثناء المقابلة؟ نعم () لا () . إذا أجبت بنعم فما هي اللغة التي تتحدثها في المنزل؟

Department of Human Services (DHS) no discrimina contra ningún individuo o grupo a causa de su raza, sexo, religión, edad, origen nacional, color de piel, estatura, peso, estado matrimonial, creencias políticas o incapacidad. Si usted necesita ayuda para leer, escribir, oír, etc., bajo la Acta de Americanos con Incapacidades, usted está invitado a hacer saber sus necesidades a una oficina de DHS en su área.

لن تميز إدارة الخدمات الإنسانية (Department of Human Services) ضد أي شخص أو مجموعة بسبب العرق، الجنس، الديانة، العمر، المنشأ الوطني، اللون، الطول، الوزن، الحالة الزوجية، أو الإعاقة والعجز. إن كنت تحتاج إلى مساعدة في القراءة والكتابة والسمع... إلخ، ندعوك أن تجعل احتياجاتك معروفة لدى مكتب في الكاونتي التي تعيش فيها عملاً بقانون الأمريكيين ذوي الإعاقة والعجز (Americans with Disabilities Act).

PLEASE READ CAREFULLY

FOR NURSING FACILITY PATIENTS ONLY

Complete this form if your are in a nursing facility. Please read each item carefully before you answer it. The answers you give will be used to determine if your are eligible for Medicaid. Be sure to sign your name on page 4.

You can apply for Medicaid by mailing or having someone take this form into your local Department of Human Services office. Your application must be approved or denied within:

- 45 days, or
- 60 days if disability is a factor in determining your Medicaid eligibility.

Use Form DHS-1171, Assistance Application, if other family members want help with medical expenses.

LOCAL OFFICE:

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: 42 CFR PART 435.
 COMPLETION: Voluntary.
 PENALTY: No Medicaid.

Note: This application requests information about the patient in the nursing facility.
The words “You” and “Your” refer to the patient.

1. Patient's Name (First, Middle, Last)		2. Name of Nursing Facility		
3. Address of Nursing Facility		City	State	Zip Code
4. Phone No. of Nursing Facility	5. County	6. Birthdate	7. Sex	8. Social Security Number
9. Marital Status: <input type="checkbox"/> Never married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
10. Date of Nursing Facility Admission		11. Address where you lived before you entered the nursing facility		

12. If married, tell us about your spouse and all persons living with your spouse.
If not married, tell us about your children under age 18 living in your home.

Name	Date of Birth	Social Security Number (Optional)	Relationship to you

If you have a court-appointed guardian/conservator, enter information below:

13. Name of Guardian/Conservator	Phone Number	Do you pay guardian/conservator expenses? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Guardian's/Conservator's Address	City	State	Zip Code

	YES	NO		YES	NO
14. Have you ever applied for or received assistance in Michigan?	<input type="checkbox"/>	<input type="checkbox"/>	21. Do you have unpaid medical expenses for services provided in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you received money or benefits such as Medical Assistance from another state in the last 30 days?	<input type="checkbox"/>	<input type="checkbox"/>	22. Do you pay health insurance premiums?	<input type="checkbox"/>	<input type="checkbox"/>
16. Are you a U.S. citizen?	<input type="checkbox"/>	<input type="checkbox"/>	23. Do you have Medicare?	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you intend to stay in Michigan?	<input type="checkbox"/>	<input type="checkbox"/>	24. Are you covered by a health, hospital, or long-term care insurance policy or were you covered in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
18. Enter your racial heritage from codes below. If you are multiracial, you may enter all the codes that apply. (Answering is voluntary.) I = American Indian, A = Alaskan Native, S = Asian, B = Black or African American, P = Native Hawaiian or Other Pacific Islander, W = White			25. Has a court ordered anyone to pay your medical expenses or provide health insurance for you?	<input type="checkbox"/>	<input type="checkbox"/>
19. Check the box if you are Hispanic or Latino (Answering is voluntary).	<input type="checkbox"/>		26. Have you had an accident or work-related illness or injury resulting in medical costs that may be paid by another person or an insurance company?	<input type="checkbox"/>	<input type="checkbox"/>
20. Are you a veteran or the spouse, dependent or parent of a veteran?	<input type="checkbox"/>	<input type="checkbox"/>	27. Have you set up a plan or entered into a contract, such as a life care contract, that will pay for your medical care?	<input type="checkbox"/>	<input type="checkbox"/>

28. **Assets:** Complete the **assets** section by providing the requested asset information for you and your spouse. List your assets and your spouse's assets. Include assets you own jointly with family or other persons, including your spouse. Include assets your spouse owns jointly with you, family or other persons. Each item must be answered **YES** or **NO**. If answered **YES**, enter amount or current value and owner(s).

Type of Asset	YES	NO	Amount or Value	Owner(s) of Asset
Cash on hand, in a safety deposit box or patient trust fund				
Home, life estate/life lease				
Real estate, not your home				
Mortgage, land contract or other notes payable to you				
Savings bonds or money market funds				
Stocks or mutual funds				
Pension, IRA, KEOGH, 401K or deferred compensation account(s)				
Trust funds				
Life Insurance				
Annuity				
Cars, vans, trucks, campers, boats, snowmobiles, other vehicles				
Tools and equipment, livestock or crops				
Funeral contracts				
Burial plot, casket, etc.				
Are there any other assets? (Please Explain)				

Checking/Draft Accounts — Savings/Share Accounts — Certificates of Deposit

Name(s) on the Account	Name and Address of Bank Credit Union, Savings and Loan	Account Number	Balance

- | | YES | NO |
|--|--------------------------|--------------------------|
| 29. Have you received a one-time cash payment in the last 36 months (3 years) such as an insurance settlement, lawsuit award, worker's compensation, lottery winnings, etc.? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you have a pending lawsuit that may bring property or money to you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Within the last 36 months (3 years) have you or a joint owner or other person whose name is also listed on the asset: | | |
| • sold, give away, or transferred ownership in any asset such as those listed above? | <input type="checkbox"/> | <input type="checkbox"/> |
| • removed or added a name on any asset such as those listed above? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you or someone acting for you ever put any money, income, lawsuit settlement or assets in a trust, annuity or similar device? | <input type="checkbox"/> | <input type="checkbox"/> |

33. **Income:** Include income for yourself and everyone listed in question 12.

Is anyone employed or self-employed? ☐ YES ☐ NO If YES, complete the following for each employed person.

Persons employed or self employed	Employer name	Wages before deductions	How often paid: weekly, every 2 wks, monthly, other	Days of week paid
		\$		
		\$		
		\$		

Every item below must be answered YES or NO.

Type of Income	YES	NO	Amount	Whose Income
Social Security Benefits (RSDI) Claim #				
Supplemental Security Income (SSI)				
Retirement Benefits				
Veterans Benefits				
Disability Benefits				
Rental Income				
Workers Compensation				
Child Support				
Unemployment Compensation				
Military Allotments				
Gaming Distributions (Casino Profit Sharing)				
Is there any other income? (Please explain)				

34. This section is about your spouse's home. Skip if you are not married.

Address where your spouse lives			Spouse's Telephone Number
City	State	Zip Code	County

Household Expenses — Check YES or NO and write in the answer about your spouse's home.

	YES	NO	AMOUNT	HOW OFTEN PAID
Do you and/or your spouse have a rent, mortgage or other shelter expense?				
Do you and/or your spouse have the following expenses separate from rent or mortgage:				
• Renter's Insurance				
• Property Taxes				
• Mobile Home Lot Rent				
• Special Assessments				
• Homeowner's Insurance				
• Mortgage Guarantee Insurance				
• Cooperative or Condominium Fee				
Do you and/or your spouse have an obligation to pay for heat and/or utilities?				

ASSIGNMENT OF BENEFITS

Recovery of Medical Costs. I understand that when the Michigan Department of Community Health (MDCH) pays the cost of hospital, surgical, or medical services, any right to recover costs from a third person or public or private contractor, except Medicare, is transferred to the MDCH. Payment of any recovery under such right is to be made directly to the State of Michigan — MDCH.

RELEASES

Social Security Information. I will allow the Social Security Administration to give to the Department of Human Services all information necessary to determine my eligibility for benefits under the Medicaid program until the second month following the expiration of my eligibility based on the current application.

Eligibility Information. I understand that the information I have provided will be used to determine my eligibility for Medicaid only and for purposes of administering the Medicaid program.

AFFIDAVIT

Under penalties of perjury, I swear that this application has been examined by or read to me, and, to the best of my knowledge, the facts are true and complete. If I am a third party applying on behalf of another person, I swear that this application has been examined by or read to the applicant, and, to the best of my knowledge, the facts are true and complete.

I certify, under penalty of perjury, that all information that I have written on this form or told to a specialist is true. I understand that I can be prosecuted for perjury if I have intentionally given false information. I also know that I may be asked to show proof of any information I have given. I also know that if I have intentionally left out any information or if I have given false information, which causes me to receive assistance I am not entitled to or more assistance that I am entitled to, I can be prosecuted for fraud. I understand I must report changes in income, assets or health insurance coverage to the department with 10 days of the change.

If you have any questions, contact your specialist or the local Department of Human Services before signing the application.

IMPORTANT: YOU MUST SIGN THE APPLICATION

I certify that I have received and reviewed a copy of the Acknowledgments that explains additional information about applying for and receiving Medicaid.

Signature (Patient or Representative)	Date	Two Witnesses only if signed by X	Date
		1. _____	
		2. _____	
Signature (Patient or Representative)	Date	Two Witnesses only if signed by X	Date
		1. _____	
		2. _____	

If you sign this application on behalf of someone else, complete the information below.

Name of person completing application	Phone Number	Relationship to patient	
Street Address	City	State	Zip Code

PLEASE KEEP THIS PAGE.
Tear out along the dotted line.

INFORMATION ABOUT MEDICAID

Rules may have changed since this was printed. Check with your local DHS office.

“You” and “Your” below refer to the patient. “We” means the Department of Human Services.

If you need help with past, unpaid medical expenses, Medicaid coverage may begin three months before you apply.

You can have Medicaid even if you are not a U.S. citizen. Coverage might be limited to just emergency services.

There are limits on the amount of income and assets you can have and be eligible for Medicaid.

Receiving Medicaid Services

You must tell all your providers (doctors, hospital, pharmacy, etc.) that you have applied for Medicaid before you receive any new medical services. Not all providers accept Medicaid. Choose a provider who does accept Medicaid.

You must give your medical provider a copy of your mihealth card or approval letter as soon as it is received. This letter tells when your eligibility began. Your providers need this information to receive prompt payment for medical services provided to you. This information is also needed to issue you a refund if you pay for a Medicaid covered service between the date your Medicaid is approved as a result of your hearing request.

We might approve Medicaid for up to 3 months before you applied. If we do, ask your providers to bill Medicaid for any covered services you received during those months. If you paid for any of these bills before you received the approval letter, ask your health providers if they will refund your money and bill Medicaid. Providers are not required to do this, but many will.

Your providers must submit your bills to Medicaid within 12 months after the date you received the services. If they wait more than 12 months, then Medicaid may not pay the bill unless the delay in billing is because you had to file an appeal to get Medicaid benefits.

Income

You meet the income test if your income is not enough to pay your medical expenses. Usually you will pay part of your nursing facility expenses and Medicaid will pay the rest. If you have a spouse or children at home, a portion of your income might be protected for them.

We count income such as Social Security benefits, pensions, rent income and veterans benefits.

Assets

Countable assets must be at or below the \$2,000 asset limit at least part of each month for which Medicaid is requested. If you have a spouse at home:

We count your assets and your spouse's assets initially. We protect a substantial amount of assets for your spouse. The remainder cannot exceed \$2,000 for you to be eligible for Medicaid.

Once initial eligibility is established, we only count your assets. The asset limit is \$2,000.

If your assets are more than the asset limit, you may become eligible for Medicaid if you use your excess assets to pay some of your medical bills, living expenses, or other debts. You may be asked to verify when and for what purposes you used your excess assets.

Medicaid might not pay for your care if you or your spouse transfer assets or income for less than fair market value. We look at transfers that occur up to 36 months (60 months for some trusts) before, or any time after, you first date of application for Medicaid while in a nursing facility.

Nursing Facility Eligibility (MDCH Publication 726) - explains eligibility for persons in or entering a nursing facility.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

ACKNOWLEDGMENTS

State of Michigan
Department of Human Services

This is your copy of your rights and responsibilities as an applicant for or recipient of Medicaid benefits. By signing the application you acknowledge that you understood your rights and responsibilities and that you applied only for Medicaid.

ASSIGNMENT OF BENEFITS

1. **Recovery of Medical Costs.** I understand that when the Michigan Department of Community Health (MDCH) pays the cost of hospital, surgical, or medical services, any right to recover costs from a third person or public or private contractor, except Medicare, is transferred to the MDCH. Payment of any recovery under such right is to be made directly to the State of Michigan - MDCH.

ACKNOWLEDGEMENTS

2. **Non-discrimination.** I understand that if I believe I have been discriminated against because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs, I have the right to file a complaint with the: Regional Manager, Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Chicago, IL 60601, 800-368-1019, 800-537-7697 TDD.
3. **Reporting Changes.** I understand that the department needs to know about changes that may affect my Medicaid. I will tell the department of any changes within 10 days of the change. I understand that if I intentionally do not do this, I can be prosecuted for fraud or perjury.

The types of changes that **MUST** be reported are:

- Receipt of or increase in income such as social security, veterans benefits, railroad retirement, pensions, retirement, disability or sick benefits.
- Discharge or move from the nursing facility to another living arrangement.
- Changes in health or hospital insurance coverage or amount of premiums.
- Any accident or work-related illness or injury where medical costs may be paid by another person or an insurance company.
- Another person or an insurance company has agreed to pay my medical expenses or is ordered to by the court.
- Receipt of a sum of money.
- Receipt of an inheritance, bank account, or other property or income from or on behalf of another person.

If you have any doubt about whether you should report a change in circumstances, ask you local Department of Human Services.

4. **Hearings.** I understand that if I do not agree with any decision made on any matter concerning my case I have the right to ask for an Administrative Hearing. I understand that I can ask for information about an Administrative Hearing by calling my local Department of Human Services.

I understand that if I want someone else to request a hearing for me or represent me in a hearing, that person must first have written authorization to do so unless that person is my attorney or my spouse. The Department of Human Services Administrative Hearings must have one of the following:

- my original signed statement authorizing the person to request a hearing, or
- a copy of the court order naming the person as my guardian or conservator.

Otherwise, my hearing request will be denied.

5. **Repayment of Benefits.** I understand that if I receive more benefits than I am entitled to receive, through my fault, I may have to repay and extra benefits.
6. **Immigration Status.** I understand that, as part of determining my eligibility for Medicaid, information about me may be submitted to the Bureau of Citizenship and Immigration Services in order to verify my immigration status.
7. **Investigations.** I understand that my application might be one of those chosen for a complete investigation and a Department of Human Services representative might call on me and might contact other people in order to verify my eligibility for assistance.
8. **Computer Cross-checking.** I understand that, as part of determining my eligibility for Medicaid, information I give on this application will be verified by computer cross-checking with other public and private agencies.

Wages reported by my employer(s) to the Department of Labor and Economic Growth will be checked against wage information I report to the Department of Human Services. My Social Security Number will be used to check this information. Through-out the year, my Social Security Number will also be checked with other sources such as the Internal Revenue Service (IRS), Unemployment Compensation and the Social Security Administration concerning income or assets.

The information obtained through this cross-checking may be verified through collateral contact when discrepancies are found. The information may affect both my eligibility for the level of my benefits.

9. **Medical Information.** By signing this application, I understand that the Department of Human Services and Michigan Department of Community Health, may get and use* necessary medical information about me or any of my wards or my minor children including any information relative to HIV, ARC or AIDS if applicable. This information will only be obtained and used as necessary to determine eligibility for a specific program or for other program administration purposes.

*Some examples of uses are with auditors, caregivers, etc. State law (MCL 333.5131 (8)) provides that a person who shares HIV, ARC or AIDS information except as authorized by this release or by law may be found "guilty of a misdemeanor punishable by imprisonment for not more than 1 year or a fine of not more than \$5,000.00, or both, and is liable in a civil action for actual damages or \$1,000.00, whichever is greater, and costs and reasonable attorney fees."

10. **Social Security Information.** I will allow the Social Security Administration to give to the Department of Human Services all information necessary to determine my right to benefits under Medicaid until the second month following the expiration of my eligibility based on the current application.
11. **Eligibility Information.** I understand that the information I have provided will be used to determine my eligibility for Medicaid only and for purposes of administering the Medicaid Program.

VERIFICATION CHECKLIST **Michigan Department of Human Services (DHS)**

We need your help to determine your eligibility for: ☐ Family Independence Program,
☐ Child Development & Care, ☐ State Disability Assistance, ☐ Medical Assistance,
☐ Food Assistance Program, ☐ SER, ☐ Other: _____

To help us, please: ☐ Complete and return the enclosed application.

☐ Bring checked proofs to your interview, return by mail, or bring to DHS.

☐ Attend an interview on _____ at _____
 Location: _____

☐ _____ must also come to the interview

Grantee Name				
Grantee Client ID				
Case Number			Date	
County	District	Section	Unit	Specialist
Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, sexual orientation, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.				
Important Information: Call me right away if you cannot come to the interview or if you have any questions or problems getting the proofs. I will help you get the proofs if you ask for help. If the information must be provided on an DHS form, the form is enclosed. You must get the proofs to me or call me by the due date below. If you do not, your benefits may be denied or cancelled.				

DUE DATE	SPECIALIST NAME	TELEPHONE	FAX #
PERSONAL AND MEDICAL RECORDS <input type="checkbox"/> Drivers license/ID card(s) for _____ <input type="checkbox"/> Social Security card(s) for _____ <input type="checkbox"/> Health insurance card(s) for _____ <input type="checkbox"/> Proof of school attendance (DHS-3380) _____ <input type="checkbox"/> Proof of immigration/alien status for _____ <input type="checkbox"/> Copy of court papers on divorce, separation or child support. <input type="checkbox"/> Paternity acknowledgment for _____ <input type="checkbox"/> DHS-1201, Non-FIP Child Support Services Application <input type="checkbox"/> DHS-4578, Child Care Education Verification <input type="checkbox"/> DHS-4575, Child Care Family Preservation Need Verification <input type="checkbox"/> DHS-4025, Child Care Provider Verification <input type="checkbox"/> DHS-220-A, Day Care Aide Provider Application <input type="checkbox"/> DHS-220-R, Relative Care Provider Application <input type="checkbox"/> Proof of pregnancy and expected date of delivery <input type="checkbox"/> DHS-54-A, Medical Needs <input type="checkbox"/> DHS-49, Medical Examination Report		ASSET RECORDS (For you and everyone living in your home) <input type="checkbox"/> Current (within last 30 days) bank statements for all savings, checking, and money market accounts (DHS-20, Verification of Assets.) <input type="checkbox"/> Titles to any cars, trucks, snowmobiles, campers, boats, farm equipment, motorcycles, trailers, etc., that you own or are buying <input type="checkbox"/> Records of any assets sold or transferred in the last 60 months <input type="checkbox"/> Proof of current status of pending lawsuit(s) <input type="checkbox"/> Statement from a nursing home of money held for you <input type="checkbox"/> Copy of original trust papers and any changes made <input type="checkbox"/> Proof of current value and availability of: stocks, bonds, notes, saving certificates, annuities, IRA or 401K accounts. <input type="checkbox"/> Records of all mortgages or land contracts you hold <input type="checkbox"/> Life Insurance – proof of ownership, face value, and current cash surrender value (DHS-4786, Life Insurance Verification) <input type="checkbox"/> Burial accounts or contracts <input type="checkbox"/> Bring/send records for all assets that you have	
INCOME RECORDS (For you and everyone living in your home) Proof of the Amount Received: <input type="checkbox"/> DHS-38, Verification of Employment Income <input type="checkbox"/> Paycheck stubs for _____ <input type="checkbox"/> Records of self employment income and expenses (DHS-431) for _____ <input type="checkbox"/> Income from renters, roomers, and/or boarders <input type="checkbox"/> Unemployment Compensation (DHS-32, UCB Information Request) <input type="checkbox"/> Child support or alimony for _____ <input type="checkbox"/> Military allotment <input type="checkbox"/> Social Security/Supplemental Security Income (RSDI/SSI) <input type="checkbox"/> Veterans Benefits <input type="checkbox"/> Pension/Retirement Income <input type="checkbox"/> Sick pay, Workers Compensation or disability benefits <input type="checkbox"/> Tribal Gaming Revenue (casino profit sharing) <input type="checkbox"/> Bring/send records of all income that you have		HOUSEHOLD EXPENSES <input type="checkbox"/> DHS-3688, Shelter Verification <input type="checkbox"/> Current proof of rent, mortgage or land contract payments <input type="checkbox"/> Property tax and insurance bills on your home for past year <input type="checkbox"/> Current bills or receipts for gas, electricity, sewage and water, garbage removal, telephone <input type="checkbox"/> Current medical or child care bills or receipts <input type="checkbox"/> Health or medical insurance premium proof <input type="checkbox"/> Child support expenses – court order and proof of payment <input type="checkbox"/> Other	

Department of Human Services (DHS) no discrimina contra ningún individuo o grupo a causa de su raza, sexo, religión, edad, origen nacional, color de piel, estatura, peso, estado matrimonial, orientación sexual, creencias políticas o incapacidad. Si usted necesita ayuda para leer, escribir, oír, etc., bajo la Acta de Americanos con Incapacidades, usted está invitado a hacer saber sus necesidades a una oficina de DHS en su área.

لن تميز إدارة الخدمات الإنسانية (DHS - Department of Human Services) ضد أي شخص أو مجموعة بسبب العرق، الجنس، الديانة، العمر، المنشأ الوطني، اللون، الطول، الوزن، الحالة الزوجية، المعتقدات السياسية أو الإعاقات إن كنت تحتاج إلى مساعدة في القراءة والكتابة والتسمع. إن دعوتك أن تجعل احتياجاتك معروفة لدى مكتب DHS في المنطقة التي تعيش فيها عملاً بقانون الأمريكيين ذوي الإعاقة (Americans with Disabilities Act)

"The USDA is an equal opportunity provider and employer."

APPENDIX C

VERIFICATION OF ASSETS

State of Michigan Department of Human Services

AUTHORIZATION: You are hereby authorized to release the information requested below to the Department of Human Services.	تفويض: إنك مفوض بموجب هذا المستند أن تصرّح عن المعلومات المطلوبة أدناه إلى إدارة الخدمات الإنسانية.
AUTORIZACION: Usted está autorizado a dar la información pedida más abajo a Department of Human Services.	Signature of Client or Client's Representative _____ Date _____

					Grantee Name
					Grantee Client ID
					Case Number
County	District	Section	Unit	Specialist	
					Date

To determine eligibility for assistance it is necessary to verify assets owned by the person named below, either alone or jointly with other persons. If the account is joint, please list the names of the account members.

Please provide current information on the person indicated below. Also, please report on accounts closed within the past 36 months. A stamped, addressed envelope is enclosed for return of the completed form. Thank you.

County Department of Human Services

Authorized Signature _____

THIS SECTION IS TO BE COMPLETED BY THE SPECIALIST

Name (Type or Print)		Social Security Number	
Present Address (Number/Street)	City	State	Zip Code
Previous Address (Number/Street)	City	State	Zip Code

THIS SECTION IS TO BE COMPLETED BY FINANCIAL INSTITUTION

NOTE: Please Report on Closed Accounts if Closed Within Past 36 Months	Savings/Share Account	Certificate of Deposit	Checking/Draft Account	Long-Term Care Patient Trust Fund	Prepaid Burial Account	Other (Explain)
1. Account Number(s):						
2. Date Last Withdrawal						
3. Amount Last Withdrawal						
4. Current Balance						
5. Highest Balance For Month of _____						
6. Lowest Balance For Month of _____						

7. Is There a Safety Deposit Box? <input type="checkbox"/> Yes <input type="checkbox"/> No		8. Is There a Trust Fund? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Attach a Copy of the Trust.
9. For Each Joint Account List	10. For Each Joint Account List	11. For Each Loan Application Within Past 36 Months List:		
Account Number:	Account Number:			Account Number _____/_____/_____
Account Members:	Account Members:			Type (e.g., Auto, Home) _____/_____/_____
				Current Balance _____/_____/_____
				If collateral was used attach a copy of the loan application
12. Remarks:				
13. Signature		14. Title		15. Telephone No. ()
16. Date				

AUTHORITY: P.A., 280 of 1939. COMPLETION: Required PENALTY: Inability to determine eligibility for public assistance	The Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your county.
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LIFE INSURANCE VERIFICATION

State of Michigan
Department of Human Services

Grantee Name				Grantee Client ID	
Case Number					
County	District	Section	Unit	Specialist	Date

Specialist's Name	County	Phone
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AUTHORITY: PA 280 of 1939

COMPLETION: Required

PENALTY: Inability to determine eligibility for assistance.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

You are authorized to release information to the Department of Human Services.

Signature of Client or Representative	Date
---------------------------------------	------

INSTRUCTIONS

The person identified in Part I below says he/she has life insurance or an endowment policy through your agency or company. Please provide the information requested in Part II regarding the policy(ies) this person has. Please return in the enclosed envelope by _____ . **Thank you for your cooperation.**

PART I

Person's Name		Date of Birth	
Address (No. and Street, Apt., etc.)		City	State
		Zip Code	
Policy Number(s) Reported to Us: ▶			

TO BE COMPLETED BY LIFE INSURANCE COMPANY

PART II

	First Policy	Second Policy	Third Policy
Type of Policy	<input type="checkbox"/> Life insurance <input type="checkbox"/> Endowment Policy Maturity Date _____	<input type="checkbox"/> Life insurance <input type="checkbox"/> Endowment Policy Maturity Date _____	<input type="checkbox"/> Life insurance <input type="checkbox"/> Endowment Policy Maturity Date _____
Policy Number			
Date of Policy			
Owner's Name			
Has ownership changed so that funds go toward insured's funeral expenses?	YES NO If yes, please include copy of transfer document and funeral contract.	YES NO If yes, please include copy of transfer document and funeral contract.	YES NO If yes, please include copy of transfer document and funeral contract.
Insured's name			
Face Value when purchased	\$	\$	\$
Does this policy accumulate a cash surrender value?	YES NO	YES NO	YES NO
Cash Surrender Value (amount policy owner would receive if cashed out policy)	\$	\$	\$
Your Signature	Title	Phone	Date

RETROACTIVE MEDICAID APPLICATION

State of Michigan
Department of Human Services

AUTHORITY: Federal 42 CFR 435. **COMPLETION:** Voluntary.

PENALTY: No medical coverage will be authorized.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

Grantee Name				Grantee Client ID	
Case Number				Date	
County	District	Section	Unit	Specialist	Other ID (as required)

1. My family has unpaid medical bills for the month(s) of:

First Month	Month	Year	Second Month	Month	Year	Third Month	Month	Year
-------------	-------	------	--------------	-------	------	-------------	-------	------

▼ ANSWER QUESTIONS 2-9 FOR EACH MONTH APPLIED FOR IN QUESTION 1. ▼

2. List yourself and the name of each family member who lived with you at any time during the first month . Check yes if the person has unpaid medical expenses this month.	2. List yourself and the name of each family member who lived with you at any time during the second month . Check yes if the person has unpaid medical expenses this month.	2. List yourself and the name of each family member who lived with you at any time during the third month . Check yes if the person has unpaid medical expenses this month.
<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
3. Was a family member(s) in a hospital, nursing home, or away from home on the last day of the first month ? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, enter name of family member(s):	3. Was a family member(s) in a hospital, nursing home, or away from home on the last day of the second month ? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, enter name of family member(s):	3. Was a family member(s) in a hospital, nursing home, or away from home on the last day of the third month ? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, enter name of family member(s):
4. Explain any changes during the first month (child born, family member left or returned home, married, divorced, died, began or ended pregnancy, began or quit work) and indicate date of change.	4. Explain any changes during the second month (child born, family member left or returned home, married, divorced, died, began or ended pregnancy, began or quit work) and indicate date of change.	4. Explain any changes during the third month (child born, family member left or returned home, married, divorced, died, began or ended pregnancy, began or quit work) and indicate date of change.

INCOME: (Questions 5-7) For each month applied for, attach proof of all income received. Attach copy of court order(s) for child support paid.

5. Was any family member employed or self-employed in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, complete the following:	FIRST MONTH		SECOND MONTH		THIRD MONTH	
	Total monthly earned income before deductions	Names of children receiving child care due to employment.	Total monthly earned income before deductions	Names of children receiving child care due to employment.	Total monthly earned income before deductions	Names of children receiving child care due to employment.
Person employed:	\$		\$		\$	
	\$		\$		\$	
Name of Self-Employed Person	Gross Monthly income, minus allowable federal tax deductions (DEPRECIATION not allowed)		Gross Monthly income, minus allowable federal tax deductions (DEPRECIATION not allowed)		Gross Monthly income, minus allowable federal tax deductions (DEPRECIATION not allowed)	
6. Did any family member pay child support in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, complete the following:	Total monthly child support paid	Total monthly child support paid	Total monthly child support paid	Total monthly child support paid	Total monthly child support paid	Total monthly child support paid
Person paying expenses:	\$	\$	\$	\$	\$	\$
7. Did any family member pay guardianship/ conservator expenses in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, who pays?	7. Did any family member pay guardianship/ conservator expenses in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, who pays?		7. Did any family member pay guardianship/ conservator expenses in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, who pays?		7. Did any family member pay guardianship/ conservator expenses in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, who pays?	

APPENDIX F

8. OTHER INCOME: Include income of all family members. Each item must be answered YES or NO.									
INCOME TYPE	FIRST MONTH			SECOND MONTH			THIRD MONTH		
	YES/NO	MONTHLY AMOUNT	WHOSE INCOME	YES/NO	MONTHLY AMOUNT	WHOSE INCOME	YES/NO	MONTHLY AMOUNT	WHOSE INCOME
Social Security Benefits (RSDI)		\$			\$			\$	
Supplemental Security Income (SSI)		\$			\$			\$	
Retirement or Pension Benefits		\$			\$			\$	
Veterans Benefits		\$			\$			\$	
Disability Benefits		\$			\$			\$	
Rental Income		\$			\$			\$	
Workers Compensation		\$			\$			\$	
Child Support or Alimony		\$			\$			\$	
Unemployment compensation		\$			\$			\$	
Military Allotments		\$			\$			\$	
Gambling Distributions (Casino profit sharing)		\$			\$			\$	
Other		\$			\$			\$	

9. ASSETS: Include assets of all family members. Each item must be answered YES or NO. Attach proof of asset value for each retro month applied for.									
ASSET TYPE	FIRST MONTH			SECOND MONTH			THIRD MONTH		
	YES/NO	AMOUNT/VALUE	OWNER(S)	YES/NO	AMOUNT/VALUE	OWNER(S)	YES/NO	AMOUNT/VALUE	OWNER(S)
Cash on hand, in a safety deposit box or patient trust fund		\$			\$			\$	
Savings, Checking or Credit Union Accounts		\$			\$			\$	
Home, life estate, life lease		\$			\$			\$	
Real Estate (not your home)		\$			\$			\$	
Mortgage, land contract or other notes payable to household member		\$			\$			\$	
Savings bonds or money market funds		\$			\$			\$	
Stocks or mutual funds		\$			\$			\$	
IRA, KEOGH, 401K or deferred compensation accounts		\$			\$			\$	
Trust Fund(s)		\$			\$			\$	
Life insurance		\$			\$			\$	
Annuity		\$			\$			\$	
Cars, trucks, boats, motorcycles, other vehicles		\$			\$			\$	
Tools & Equipment, Livestock or Crops		\$			\$			\$	
Funeral contracts		\$			\$			\$	
Burial plot(s), casket, etc.		\$			\$			\$	
Certificates of Deposit (C.D.) or savings certificates		\$			\$			\$	
Other		\$			\$			\$	

I CERTIFY THAT ALL INFORMATION I HAVE WRITTEN ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

Signature	Date	Signature of Spouse	Date
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TENTATIVE PATIENT-PAY AMOUNT NOTICE

Michigan Department of Human Services

Grantee Name				
Grantee Client ID				
Case Number				
County	District	Section	Unit	Specialist
Date				
Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.				

I am reviewing your application for Medicaid. A final decision has not been made yet. You will be sent a written notice as soon as the final decision is made.

If your application is approved, you will probably have to pay part of the cost of your nursing facility care each month that you are eligible for Medicaid. We deduct the following from your income to determine how much you must pay each month toward your care:

- \$60 for your personal needs
- Health insurance premiums you pay
- Guardianship or conservator fees and expenses

Your tentative patient pay amount is _____

If your application is not approved, Medicaid will not pay any part of your medical expenses.

Medicaid may not pay any of the cost of nursing facility care if it is determined that you do **not** have a medical need for nursing facility care. You will receive a separate notice if this determination is made.

For more information about Medicaid for nursing facility patients, ask for MDCH Publication 726, Nursing Facility Eligibility. It is available at all DHS offices and most nursing facilities.

Please remember that you (or whoever is acting on your behalf) must notify me within 10 days of any change in your situation. Report discharge or move from the nursing facility and changes in income, assets, health insurance coverage and amount of premiums, and medical expenses.

Please contact me if you have any questions.

Specialist _____

Telephone _____

Office Hours: _____

County Department of Human Services

MEDICAL PROGRAM ELIGIBILITY NOTICE

Michigan Department of Human Services

<p style="text-align: center;">ملاحظة للتأجير</p> <p>الرجاء قراءة هذه النسخة من هذا النموذج قبل أن تتخذ أي قرار بشأن طلبك للحصول على الخدمات الصحية. يمكنك طلب جلسة استشارة مع أحد موظفي خدمة العملاء للحصول على مزيد من المعلومات. إذا كنت بحاجة إلى مزيد من المساعدة، يمكنك الاتصال بمكتب الخدمات الصحية في ميشيغان. يمكنك أيضًا الاتصال بمكتب الخدمات الصحية في ميشيغان للحصول على مزيد من المعلومات.</p>	<p>El frente de esta forma le avisa sobre las decisiones que tomó su especialista, para aprobar o negar su aplicación para los beneficios y para informarle sobre su ayuda mensual. Puede usar la página 2 de la forma para pedir una audiencia con un juez de ley administrativa si no está de acuerdo con la decisión tomada sobre sus beneficios.</p> <p>Si no entiende esta forma, comuníquese con su el Department of Human Services en su área al número de teléfono en esta forma.</p>										
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Grantee Name</p> <p>Grantee Client ID</p> <p>Case Number</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">County</td> <td style="width: 15%;">District</td> <td style="width: 15%;">Section</td> <td style="width: 15%;">Unit</td> <td style="width: 40%;">Specialist</td> </tr> <tr> <td colspan="5" style="height: 20px;"></td> </tr> </table> <p>Date</p> </div> <div style="width: 35%;"></div> </div>		County	District	Section	Unit	Specialist					
County	District	Section	Unit	Specialist							

This is about your _____ application or your Medicaid spend-down case. Please read pages 1 and 2 of this notice carefully. This notice applies to the following person(s): _____

The information next to the box(es) checked(✓) applies to you. Disregard the information next to the boxes that are not checked.

APPROVALS - You are eligible for: ☐ MEDICAID ☐ _____

1. ☐ Beginning _____
2. ☐ For _____
3. ☐ You are eligible for emergency and urgent care services only.
4. ☐ You may be required to pay all of the cost of long-term care services because of restrictions on long-term care payments explained below. Otherwise, you must pay the following amount(s) toward the cost of your hospital/long-term care.
 \$ _____ per month beginning _____
 \$ _____ for _____; \$ _____ for _____; \$ _____ for _____
5. ☐ Medicaid will not pay for long-term care and home and community-based waiver services from _____ through _____ because you or your spouse transferred assets or income for less than their value. Notify your specialist if you are denied emergency care because of this penalty.
6. ☐ You (and your spouse, if any) must pay \$ _____ per month to your personal care provider beginning _____
7. ☐ Medicaid will only pay your Medicare Part A, Hospital Insurance, premiums. You will not receive a mihealth card.
8. ☐ Your new specialist is _____ Telephone number _____

Medicaid may not pay any of the cost of long-term care if it is determined that you do not have a medical need for long-term care. You will receive a separate notice if this determination is made. Also see the restriction in 5 above if that box is checked.

DENIALS - You are not eligible for: ☐ MEDICAID ☐ _____

The reason(s) is:

☐ This denial applies to the month(s) of _____

MESSAGE:

Manual Policy Reference(s): PEM _____
 PAM _____

If your application is being denied, you may reapply for assistance if your circumstances change.

If you do not understand the information in this notice, please contact me immediately. If you wish, you may meet with my manager and me to discuss the action(s) taken.

Signature of Specialist	Telephone Number
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mihealth card

If you are eligible for Medicaid, your plastic mihealth card will be mailed to you within a few days. You must present the card each time an eligible person listed on the card requests medical services. The card may be used only for the eligible person whose name is listed on the card. The use of the card to obtain services for other persons is fraud. Never throw your card away. Use the same card every month as long as you receive benefits.

REPORTING CHANGES

It is your responsibility (or the responsibility of the person acting in your behalf) to notify this office within 10 days of any changes in your circumstances which may affect your eligibility for Medicaid, or other medical programs. Such changes include changes in employment, income, assets and health insurance premiums for you or members of your family, the number of persons living in your home, and change of address. Failure to report changes may make you liable to penalties provided by law for fraud.

PROCEDURES FOR REQUESTING A HEARING

If you believe this action is illegal, you may request a hearing within 90 days of the date of this notice. A hearing request must be made IN WRITING and signed by you or an authorized person. You may choose anyone to represent you. If you want someone else to request a hearing for you or represent you at the hearing, that person must first have written authorization to do so unless that person is your spouse or attorney. DHS Administrative Hearings must have proof that you have authorized the person to request the hearing or a copy of the court order naming the person as your guardian or conservator. Otherwise, your hearing request will be denied.

Complete the "Request for Hearing" section below or any other written request. State that you want a hearing on the decision made by the Agency and briefly explain your reasons. Send your written request to your local DHS office.

If you want to know more about how a fair hearing works or to find out if free legal help is available, contact your local DHS office.

REQUEST FOR HEARING

Michigan Department of Human Services

INSTRUCTIONS: Complete items 11 through 22 below. Please type or print. DELIVER OR MAIL completed form to your local DHS office, Attn: Hearings Coordinator. A date-stamped copy will be returned to you by the local office.

1. Grantee Name					
2. Program(s) in Dispute					3. Grantee Client ID
4. County	5. District	6. Section	7. Unit	8. Specialist	9. Date Received
10. Telephone Number					

Esta forma se usa para solicitar una audiencia con un juez de ley administrativa cuando usted no está de acuerdo con una decisión que se hizo tocante a su caso. Si usted no entiende esta forma o necesita ayuda para completarla, comuníquese con el Department of Human Services en su area al número de teléfono indicado en esta forma.

هذه الاستمارة تستخدم لطلب المرافعة مع حاكم قضائي إداري عندما لا توافق على قرار اتخذته إدارة قضيته. إذا لم تستطع فهم هذه الاستمارة أو حقت من مساعدة أهل الاستمارة، اتصل بالمكتب "محلي لوكالة الخدمات العائلية على الرقم لحين في الاستمارة،

AUTHORITY: 42 CFR; and Public Act 280 of 1939, as amended.
RESPONSE: Voluntary.
PENALTY: None

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

11. I request an administrative hearing before an Administrative Law Judge regarding the decision of Department of Human Services. Following are my reasons for requesting a hearing: _____
(Attach a separate sheet, if necessary.)

Name of County or State Division

By my signature below, I acknowledge that I understand that if a proposed action is not taken because I have requested a hearing and the Department's proposed action is upheld, or if I later agree that the Department's proposed action was correct and withdraw my hearing request, or if I do not appear for the hearing, then I will be required to repay any assistance which I would not have received if I had not asked for a hearing.

12. Do you have physical or other conditions requiring special arrangements for you to attend or participate in a hearing?
☐ Yes ☐ No

13. Signature of Person Requesting Hearing	14. Telephone Number	15. Date
16. Street Address or Route Number	17. City, State, and Zip Code	

THIS SECTION TO BE COMPLETED ONLY IF SOMEONE HAS AGREED TO REPRESENT YOU AT THE HEARING.

18. Name of Representative	19. Title	20. Telephone Number
21. Street Address or Route Number	22. City, State, and Zip Code	

INITIAL ASSET ASSESSMENT NOTICE

State of Michigan
Family Independence Agency

Grantee Name				
Grantee Client ID				
Case Number				
County	District	Section	Unit	Specialist
Date				

The Family Independence Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an FIA office in your county.

AUTHORITY: 42 USC 1396
PENALTY: None.
COMPLETION: Voluntary.

Please read pages 1 and 2 of this notice carefully.

This notice explains:

- The amount of assets which may be kept by the patient's spouse.
- How we calculated that amount.
- The amount of assets which may be kept by the patient.

PROTECTED SPOUSAL AMOUNT

The amount of assets which may be kept by the patient's spouse is \$ _____. The patient may keep \$2,000 in assets while on Medicaid.

Special Note: If all the patient wants is help paying Medicare premiums, coinsurances and deductibles, the patient may keep \$4,000 in assets instead of \$2,000.

The amount protected for the patient's spouse is one-half of the Initial Asset Assessment Amount (see below) but not less than \$ _____ or more than \$ _____.

INITIAL ASSET ASSESSMENT AMOUNT

The Initial Asset Assessment Amount is the value of the assets owned by the patient and spouse on the first day of the first continuous period of care that began on or after September 30, 1989. A continuous period of care is a period of at least 30 consecutive days where the patient has been, or is expected to be, in a hospital, in a nursing home or approved for the home and community-based services waiver. This date was _____. Only assets countable under Medicaid policy were considered.

The Initial Asset Assessment Amount is \$ _____.

Attached is a list of assets counted for the Initial Asset Assessment Amount and the value assigned each asset. We have enclosed a copy of the documentation used in computing the Initial Asset Assessment Amount.

Signature of Specialist Taking Action

Telephone Number

Hearing Rights

If you are dissatisfied with the Initial Asset Assessment Amount or Protected Spousal Amount, you will have the right to request a hearing. You may request a hearing only after you have actually applied for Medicaid. The deadline for requesting a hearing will be 90 days from the date of our notice regarding the patient's Medicaid eligibility.

A hearing request must be IN WRITING and signed by the applicant, his or her spouse, or an authorized person. You may choose anyone to represent you. However, if you want someone else to request a hearing for you or represent you at the hearing, that person must have written authorization to do so unless that person is your attorney. FIA Administrative Hearings must have proof that you authorized the person to request the hearing or a copy of the court order naming the person as your guardian or conservator. Otherwise, your hearing request will be denied.

If you want to know more about how a fair hearing works or to find out if free legal help is available in your area, contact your local Family Independence Agency office.

Manual Policy Reference: PEM Item 402.

ASSET TRANSFER NOTICE
Family Independence Agency

Grantee Name				
Grantee Client ID				
Case Number				
County	District	Section	Unit	Specialist
Date			Other ID (as required)	

The Family Independence Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an FIA office in your county.

AUTHORITY: 42 USC 1396
PENALTY: None.
COMPLETION: Voluntary.

Please read the front and back of this notice carefully.

All assets owned by both the patient and spouse were evaluated to determine the patient's eligibility for Medicaid.

This notice explains how much of the patient's assets may need to be transferred to the spouse so that the patient may continue getting Medicaid.

The patient's countable assets must be at or below the Medicaid asset limit of \$2,000 at the end of one year.

Special Note: The Medicaid asset limit is \$4,000 instead of \$2,000 if the patient's Medicaid coverage is limited to paying Medicare premiums, coinsurances and deductibles.

The patient has one year to complete the transfer of assets to the spouse. This period will not be extended if the amount that needs to be transferred changes. At the end of one year, the value of assets the patient owns must be at or below the Medicaid asset limit for the patient to remain eligible for Medicaid. If the value of the patient's assets increases or if the patient receives new assets during the year, these additional assets may also need to be transferred before the one-year period ends. Be sure to read the Special Rules on the back about the one-year period.

Use the Community Spouse Resource Allowance shown below to help decide how much to transfer to the patient's spouse.

The protected spousal amount	\$	
Minus the spouse's assets	\$	
Equals the Community Spouse Resource Allowance	\$	

The Initial Asset Assessment Notice sent to the patient and spouse explains how we calculated the protected spousal amount. The attached Initial Assessment and Asset Record shows the calculations we made and an itemized list of the patient's and spouse's countable assets.

If you have any questions, talk to your caseworker.

Manual Policy Reference: PEM Item 402

Name of Specialist Taking Action	Date
----------------------------------	------

Special Rules

Special rules about assets were used to determine eligibility for Medicaid. These rules apply because the patient is in a hospital, in a nursing home or approved for the home and community-based services waiver and has a spouse at home.

We will review the patient's Medicaid eligibility when we stop applying these special rules. We will stop applying these special asset rules at the end of the one-year period. We will stop sooner if any of the following happen:

- Patient's spouse enters a hospital or nursing home or is approved for the home and community-based services waiver for at least 30 consecutive days.
- Patient leaves the hospital or nursing home for at least 30 consecutive days or the home and community-based services waiver terminates for at least 30 consecutive days.
- Patient's spouse dies.
- Patient gets a divorce.

You must report any such change within 10 days of the change.

Transfers

Spouses may transfer any assets between themselves. The patient and spouse may transfer any assets to the patient's blind or disabled child.

There **are** restrictions on what the patient and spouse may transfer to others.

For more information, ask for MDCH Publication 726, "Nursing Home Eligibility".

Request for Hearing

If you are dissatisfied with the Agency's determination, you may request a hearing within 90 days of the date of this notice. A hearing request must be in **WRITING** and signed by the patient, his or her spouse, or an authorized person. You may choose anyone to represent you. However, if you want someone else to request a hearing for you or represent you at the hearing, that person must first have written authorization to do so unless that person is your attorney. FIA Administrative Hearings must have proof that you authorized the person to request the hearing or a copy of the court order naming the person as your guardian or conservator. Otherwise, your hearing request will be denied.

Mail or bring your hearing request to the Hearings Coordinator at your local Family Independence Agency office.

If you want to know more about how a fair hearing works or to find out if free legal help is available, contact your local Family Independence Agency office.

INTENT TO CONTRIBUTE INCOME
Michigan Department of Social Services

Case Name			
Case Number			
County	District	Unit	Worker
Date		Other ID (as required)	
<small>The Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap or political beliefs.</small>			
<small>AUTHORITY: 42 USC 1396 PENALTY: None COMPLETION: Voluntary</small>			

Instructions to Patient:

Read the Community Spouse and Family Income Allowance Notice first.

Complete this form, sign it, date it and return it to your local Department of Social Services office within 10 days from the date above.

Check the appropriate box to tell us what you intend to do. Fill in the dollar amount if you check the third box.

- ☐ I intend to make the entire amount of the Community Spouse Income Allowance available to my spouse each month.
- ☐ My income is not enough to contribute the entire amount of the Community Spouse Income Allowance. Therefore, I intend to contribute all my income except for money for my personal needs.
- ☐ I intend to make only \$ _____ of the Community Spouse Income Allowance available to my spouse each month.
- ☐ I do NOT intend to make any money available to my spouse.

I understand that the amount I intend to contribute to my spouse is deducted from my income in determining what I must pay towards the cost of my care in a long-term care facility or hospital.

Signature of Patient or Authorized Representative		Date
Two witnesses if signed by Mark X	Signature of First Witness	Signature of Second Witness

DSS-4592 (12-89)

AREA AGENCIES ON AGING COUNTIES OR CITIES SERVED

Area Agency on Aging 1-B

29100 Northwestern Hwy, Suite 400
Southfield, MI 48034

(248) 357-2255

Livingston, Macomb, Monroe, Oakland, St. Clair and Washtenaw

Area Agency on Aging of Northwest MI, Inc.

1609 Park Drive
P.O. Box 5946
Traverse City, MI 49686

(231) 947-8920

Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska,
Leelanau, Manistee, Missaukee, and Wexford

Area Agency on Aging of Western MI, Inc.

1279 Cedar NE
Grand Rapids, MI 49503

(616) 456-5664

Allegan, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Newaygo,
Osceola

Branch-St. Joseph Area Agency on Aging

570 Marshall Road
Coldwater, MI 49036

(517) 278-2538

Branch, St. Joseph County

Detroit Area Agency on Aging

1333 Brewery Park Blvd, Suite 200
Detroit, MI 48207

(313) 446-4444

Cities of Detroit, the Grosse Pointes, Hamtramck, Harper Woods
and Highland Park

Region II Area Agency on Aging

102 N. Main Street
Brooklyn, MI 49230-0189

(517) 592-1974

Hillsdale, Jackson, and Lenawee

Region 3-A Area Agency on Aging

3299 Gull Road
Nazareth, MI 49074

(269) 373-5147

Kalamazoo County

Region 3-B Area Agency on Aging

200 West Michigan Avenue, Suite 100
Battle Creek, MI 49017

(269) 966-2450

Barry, Calhoun

Region IV Area Agency on Aging, Inc.

2900 Lakeview Avenue
St. Joseph, MI 49085

(269) 983-0177

Berrien, Cass and Van Buren

Region IX Area Agency on Aging
Northeast MI Community Services Agency, Inc.

2375 Gordon Road
Alpena, MI 49707 (989) 356-3474

Alcona, Alpena, Arenac, Cheboygan, Crawford, Iosco,
Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle
and Roscommon

Region VII Area Agency On Aging

1615 S. Euclid Ave
Bay City, MI 48706 (989) 893-4506

Bay, Clare, Gladwin, Gratiot, Huron, Isabella, Midland,
Saginaw, Sanilac and Tuscola

Senior Resources

560 Seminole Road
Muskegon, MI 49444 (231) 739-5858

Muskegon, Oceana and Ottawa

The Senior Alliance, Inc.

3850 Second Street, Suite 201
Wayne, MI 48184 (734) 722-2830

Wayne County except for cities covered by
Detroit Area Agency on Aging

Tri-County Office on Aging

5303 South Cedar Street
Lansing, MI 48911-3800

(517) 887-1440

Clinton, Eaton and Ingham

U.P. Area Agency on Aging
UPCAP Services, Inc.

2501 14th Avenue, South
Escanaba, MI 49829

(906) 786-4701

Counties in the Upper Peninsula

Valley Area Agency on Aging

225 E. Fifth Street, Suite 200
Flint, MI 48502

(810) 239-7671

Genesee, Lapeer and Shiawassee

MICHIGAN MI CHOICE WAIVER AGENTS COUNTIES OR CITIES SERVED

Detroit, the Grosse Pointes, Hamtramck, Harper Woods, Highland Park

Detroit Area Agency on Aging

Paul Bridgewater, Executive Director

Mary O'Neil, Program Director

1333 Brewery Park Blvd., Suite 200

Detroit, Michigan 48207

Tele: 313-446-4444

Fax: 313-446-4446

Wayne County except cities served by Detroit Area Agency on Aging

The Senior Alliance

Robert Brown Executive Director

Lydia Gold, Program Director

3850 Second Street, Suite 201

Wayne, Michigan 48184-1755

Tele: 734-722-2830

Fax: 734-722-2836

or

The Information Center, Inc.

Ruth Sebaly, President

Kelly Faber, Program Director

20500 Eureka Road, Suite 110

Taylor, Michigan 48180

Tele: 734-282-7171

Fax: 734-282-7105

Livingston, Macomb, Monroe, Oakland, St. Clair and Washtenaw Counties

Area Agency on Aging 1B

Tina Abbate Marzolf, CEO
Kathleen Kueppers, Program Director
29100 Northwestern Highway, Suite 400
Southfield, Michigan 48034
Tele: 248-357-2255
Fax: 248-648-9691

or

Macomb-Oakland Regional Center, Inc.

Dennis M. Bott, Director
Marcia Marklin, Program Director
16200 Nineteen Mile Road
P. O. Box 380710
Clinton Township, Michigan 48038-0070
Tele: 586-263-8953
Fax: 586-228-7029

Hillsdale, Jackson and Lenawee Counties

Region 2 Area Agency on Aging

Ginny Wood-Bailey, Executive Director
Barbara Stoy, Waiver Services Manager
102 North Main Street
PO Box 189
Brooklyn, Michigan 49230
Tele: 800-335-7881
517-467-2204
Fax: 517-467-8214

Clinton, Eaton and Ingham Counties

Tri-County Office on Aging

Marion Owen, Director
5303 South Cedar Street
Lansing, Michigan 48911-3800
Tele: 517-887-1440
Fax: 517-887-8071

Barry, Branch, Calhoun, Kalamazoo and St. Joseph Counties

Burnham Brook Center

Karla Fales, Director
200 West Michigan Avenue, Suite 100
Battle Creek, Michigan 49017
Tele: 269-441-0902
Fax: 269-966-2479

or

Senior Services, Inc.

Robert W. Littke, Director
John Grib, Program Director
918 Jasper Street
Kalamazoo, Michigan 49001
Tele: 269-382-0515
Fax: 269-382-3189

Berrien, Cass, and Van Buren Counties

Region IV Area Agency on Aging

Lynn Kellogg, Chief Executive Officer
John Altena, Program Director
2900 Lakeview Avenue
St. Joseph, Michigan 49085
Tele: 269-983-0177
Fax: 269-983-5218

or

Burnham Brook Center

Karla Fales, Director
200 West Michigan Avenue, Suite 100
Battle Creek, Michigan 49017
Tele: 269-441-0902
Fax: 269-966-2479

Genesee, Lapeer, and Shiawassee Counties

Valley Area Agency on Aging

Kathy Boles, Director
Yaushica Brown, CM Supervisor
711 North Saginaw Street, Suite 207
Flint, Michigan 48503
Tele: 810-239-7671
Fax: 810-239-8869

**Bay, Clare, Gladwin, Gratiot, Huron, Isabella, Midland, Saginaw, Sanilac,
and Tuscola Counties**

A&D Home Health Care, Inc.

Roselyn Argyle, Director
David Benjamin, Program Director
3150 Enterprise, Suite 200
Saginaw, Michigan 48603
Tele: 1-800-884-3335
989-249-0929
Fax: 989-249-1147 / 989-249-1153 - Roselyn Argyle

or

Region VII Area Agency on Aging

Bruce King, Director
Kerry Williams, Program Director
1615 S. Euclide Avenue
Bay City, Michigan 48706
Tele: 989-893-4506
Fax: 989-893-3770

Upper Peninsula Counties

U.P. Area Agency on Aging (UPCAP)

Jonathan Mead, Director
Mark Bomberg, Program Director
P.O. Box 606
2501 14th Avenue South
Escanaba, Michigan 49829
Tele: 906-786-4701
Fax: 906-786-5853

**Allegan, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Newago, and
Osceola Counties**

Area Agency on Aging of Western Michigan, Inc.

Thomas Czerwinski, Director
Suzanne Filby-Clark, Program Director
1279 Cedar Street, N.E.
Grand Rapids, Michigan 49503-1378
Tele: 616-456-5664
Fax: 616-456-5692

or

HHS, Health Options

Denise L. Zoeterman, President and CEO
Steven Velzen-Haner, Clinical Director
5363 44th Street, S.E.
Grand Rapids, Michigan 49512
Tele: 800-634-2712
616-285-2590
Fax: 616-285-2588

**Alcona, Alpena, Arenac, Cheboygan, Crawford, Iosco, Montmorency,
Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon Counties**

Northeast Michigan Community Service Agency (NEMCSA)

John Swise, Director
Laurie Sauer, Program Director
2375 Gordon Road
Alpena, Michigan 49707
Tele: 989-356-3474
Fax: 989-354-5909

or

Northern Michigan Regional Health Systems

Diane Lagerstrom, Program Director
Melody Boughner
416 Connable Avenue
Petoskey, Michigan 49770-2297
Tele: 231-487-5305
Fax: 231-487-4880

**Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelenau,
Manistee, Missaukee, Wexford Counties**

Area Agency on Aging of Northwest Michigan

Gregory Piaskowski, Executive Director
Robert Schlueter, Program Director
1609 Park Drive, P. O. Box 5946
Traverse City, Michigan 49696-5946
Tele: 231-947-8920
Fax: 231-947-6401

or

Northern Lakes Community Mental Health

Gregory D. Paffhouse, Director
Terri Kelty, Program Director
105 Hall Street, Suite D
Traverse City, Michigan 49684
Tele: 800-640-7478
231-933-4917
Fax: 231-995-7900

Muskegon, Oceana and Ottawa Counties

Senior Resources

Dee Scott, Director
Cheryl Snow, Program Director
255 West Sherman Boulevard
Muskegon Heights, Michigan 49444
Tele: 231-739-5858
Fax: 231-739-4452

or

HHS, Health Options, Inc.

Denise L. Zoeterman, Director
Steven Velzen-Haner, Clinical Director
5363 44th Street, S.E.
Grand Rapids, Michigan 49512
Tele: 616-285-2590
Fax: 616-285-2588

MICHIGAN LONG-TERM CARE CONNECTIONS

Statewide Toll-Free Number:
866-642-4582

Detroit/Wayne County LTC Connection

1333 Brewery Park Boulevard, Suite 160

Detroit, Michigan 48207

Project Director: Earlene Traylor Neal

Telephone: 313-446-4444

Service Area: Cities of Detroit, Grosse Pointe (GP), GP Farms, GP Park, GP Shores, GP Woods, Hamtramck, Harper Woods, and Highland Park. Considering an expansion to western Wayne County in late 2007

Southwest Michigan LTC Connection

2900 Lakeview Avenue

St. Joseph, MI 49085

Project Director: John Altena

Telephone: 269-983-0177

Partner Sites:

Kalamazoo County/Area Agency on Aging (AAA) IIIA

3299 Gull Road

Nazareth, MI 49074

Telephone: 269-373-5224

Service Area: Kalamazoo County

Burnham Brook Center/AAA IIIB

200 West Michigan Avenue

Battle Creek, MI 49017

Telephone: 269-966-2475 or toll free 1-800-626-6719

Service Area: Calhoun and Barry counties

Branch-Hillsdale-St. Joseph Community Health/AAA IIIC

570 Marshall Road
Coldwater, MI 49036
Telephone: 517-278-2494
Service Area: Branch and St. Joseph counties

Region IV Area Agency on Aging

2900 Lakeview Avenue
St. Joseph, MI 49085
Telephone: 800-654-2810
Service Area: Berrien, Cass, and Van Buren counties

West Michigan LTC Connection

3600 Camelot Dr. S.E., Suite 2
Grand Rapids, MI 49546
Project Director: Chuck Logie
Telephone: 616-956-6627
Service Area: Allegan, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Osceola, and Ottawa counties

Upper Peninsula LTC Connection

P.O. Box 606
Escanaba, MI 49829
Project Director: Mark Bomberg
Telephone: 906-786-4701
Service Area: Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft counties

Walk-in locations:

Escanaba: 2501 14th Avenue South; (906) 786-4701

Iron Mountain: 800 Crystal Lake Blvd, Suite 111; (906) 774-9918

Marquette: 2803 US 41 West, Suite 120; (906) 228-6169

Sault Ste. Marie: 223 W. Portage Avenue, Suite A; (906) 632-9835

MICHIGAN DEPARTMENT OF HUMAN SERVICES

LOCAL OFFICE INFORMATION

County	Director	Address	Phone
Alcona	Karin Hobbs	205 North State Harrisville MI 48740	(989) 724-5716
Alger	Robyn Loviska	101 Court St. Munising MI 49862	(906) 387-4440
Allegan	Susan Bailey-Carman	3255 122nd Allegan MI 49010	(269) 673-7700
Alpena	Doug McCombs	711 W. Chisholm Alpena MI 49707	(989) 354-7200
Antrim	Fred Harris	205 E. Cayuga Bellaire MI 49615	(231) 533-8664
Arenac	Bernell Wiggins	3709 Deep River Road Standish MI 48658	(989) 846-5500
Baraga	Louisa D. Wills	108 Main Street Baraga MI 49908	(906) 353-4700
Barry	Don Rewa	430 Barfield Drive Hastings MI 49058	(269) 948-3200
Bay	Bernell Wiggins	1399 W. Center Rd. Essexville MI 48732	(989) 895-2100
Benzie	Doug Lapham	448 Court Plaza Government Center Beulah MI 49617	(231) 882-1330
Berrien	Jerry S. Frank	401 Eighth Street Benton Harbor MI 49023	(269) 934-2000

Branch	Tim Kelly, Acting	388 Keith Wilhelm Dr. Coldwater MI 49036	(517) 279-4200
Calhoun	Gwain McCree	190 E. Michigan Battle Creek MI 49016	(269) 966-1284
Cass	Chris Kadulski	325 M-62 Cassopolis MI 49031	(269) 445-0200
Charlevoix	Bill Denemy	2229 Summit Park Dr Petoskey MI 49770	(231) 348-1600
Cheboygan	Kenneth DesArmo	827 S. Huron St. Cheboygan MI 49721	(231) 627-8500
Chippewa	Kathleen Langhals	463 East 3 Mile Sault Ste. Marie MI 49783	(906) 635-4100
Clare	Howard Sweeney	725 Richard Dr. Harrison MI 48625	(989) 539-4260
Clinton	Sue Fulton, Acting	201 W. Railroad St. Johns MI 48879	(989) 224-5500
Crawford	Robert Lewis, Acting	230 Huron Grayling MI 49738	(989) 348-7691
Delta	Russ Sexton	2940 College Ave. Escanaba MI 49829-9596	(906) 786-5394
Dickinson	Bob Roberge	1238 Carpenter Ave. Iron Mountain MI 49801	(906) 774-1484
Eaton	Don Rewa	1050 Independence Blvd. Charlotte MI 48813	(517) 543-0860
Emmet	Bill Denemy	2229 Summit Park Drive Petoskey MI 49770	(231) 348-1600
Genesee	Sheryl Thompson,	125 E. Union St. Flint MI 48501	(810) 760-2200

McCree District 02	Barbara Anders	630 S. Saginaw St. Flint MI 48501	(810) 760-7300
Children's District 03	Sonia Latta	125 E. Union St. Flint MI 48501	(810) 760-2888
North District 05	Randy Rauch	125 E. Union St. Flint MI 48501	(810) 760-2773
Pierson Road District 06	Ron Logan	2320 W. Pierson Rd. Flint MI 48501	(810) 787-7101
Hillsdale	Tim Kelly, Acting	40 Care Drive Hillsdale MI 49242	(517) 439-2200
Houghton	Louisa D. Wills	200 Quincy St. Hancock MI 49930	(906) 482-0500
Huron	Leonard Richards	1911 Sand Beach Rd. Bad Axe MI 48413	(989) 269-9201
Ingham	Susan Hull	5303 S. Cedar St. Lansing MI 48911	(517) 887-9400
Ionia	Philip L. Larson	920 E. Lincoln Ionia MI 48846	(616) 527-5200
Iosco	Karin Hobbs, Director	2145 E. Huron Rd. East Tawas MI 48730	(989) 362-0300
Iron	Bob Roberge	337 Brady Avenue Caspian MI 49915	(906) 265-9958
Isabella	Mark Stevens	1475 S. Bamber Rd. Mt. Pleasant MI 48858	(989) 772-8400
Jackson	Tanda Reynolds	301 E. Louis Glick Hwy. Jackson MI 49201	(517) 780-7400

Kalamazoo	Sherry Thomas-Cloud	322 E. Stockbridge Ave. Kalamazoo MI 49001	(269) 337-4900
Kalkaska	Fred Harris	503 North Birch Street Kalkaska MI 449646	(231) 258-1200
Kent	Andrew L. Zylstra	415 Franklin, S.E. Grand Rapids MI 49507	(616) 247-6000
Keweenaw	Louisa D. Wills	3616 Highway US-41 Mohawk MI 49950	(906) 337-3302
Lake	Jim McCormick	5653 S. M-37 Baldwin MI 49304	(231) 745-8159
Lapeer	Irene Bazan Waller	1505 Suncrest Dr. Lapeer MI 48446	(810) 667-0800
Leelanau	Fred Harris, Acting	701 S. Elmwood Traverse City MI 49684	(231) 941-3900
Lenawee	Joseph A. Satterelli	1040 S. Winter St. Adrian MI 49221	(517) 264-6300
Livingston	Susan Fulton	2300 E. Grand River Howell MI 48843	(517) 548-0200
Luce	Kathleen Langhals	500 W. McMillan Newberry MI 49868	(906) 293-5144
Mackinac	Ken DesArmo	199 Ferry Lane Saint Ignace MI 49781	(906) 643-9550
Macomb	Angelo Nicholas	19700 Hall Rd., Clinton Township 48038	(586) 412-6100
Mt.Clemens	Yvonne Brock	21885 Dunham Rd. Clinton Township 48036	(586) 469-7700

Warren	Amy Hundley-Dantzler	27690 Van Dyke Avenue Warren MI 48093	(586) 427-0600
Sterling Heights	Patricia Sera	44600 Delco Blvd. Sterling Heights MI 48313	(586) 254-1500
Mecosta	Dennis Major	800 Water Tower Rd. Big Rapids MI 49307	(231) 796-4300
Menominee	Russ Sexton	2612 10th St. Menominee MI 49858	(906) 863-9965
Midland	Mark Stevens	1509 Washington Midland MI 48641	(989) 835-7040
Missaukee	Dave VanHouten	10641 W. Watergate Rd. Cadillac MI 49601	(231) 779-4500
Monroe	Terrence Beurer	903 S. Telegraph, Monroe MI 48161	(734) 243-7200
Montcalm	Philip L. Larson	609 N. State Stanton MI 48888	(989) 831-8400
Montmorency	James Beach	11636 M-32, West Atlanta MI 49709	(989) 785-4218
Muskegon	Jane Johnson	2700 Baker St. Muskegon Heights 49444	(231) 733-3700
Newaygo	James H. McCormick	1018 Newell White Cloud MI 49349	(231) 689-5500
Oakland	Dorothy Butler, Acting	Oakland Towne Center 28 N. Saginaw St Pontiac MI 48342	(248) 975-4800

Baldwin Road District	Dianna Pyles, Acting	Child & Family Services 1685 Baldwin Rd. Pontiac MI 48340	(248) 975-5400
Madison Heights	Velvet Savage	30755 Montpelier Madison Heights 48071	(248) 583-8700
Walled Lake District	Donald Dersnah	195 Ladd Rd. Walled Lake MI 48390	(248) 669-7600
Saginaw Street District	Bill Holland	235 N. Saginaw Pontiac MI 48342	(248) 975-5200
Oscoda	James Beach	200 W. Fifth St. Mio MI 48647	(989) 826-4000
Otsego	Robert Lewis, Acting	1999 Walden Dr Gaylord MI 49735	(989) 732-1702
Ottawa	Loren Snippe	12185 James St., Ste. 200 Holland MI 49424	(616) 394-7200
Presque Isle	Doug McCombs	1242 W. Third St. Rogers City MI 49779	(989) 734-2108
Roscommon	Walter Kaniszewski	111 Union St. Roscommon MI 48653	(989) 275-5107
Saginaw	Randy Barst	411 E. Genesee Saginaw MI 48605-9931	(989) 758-1500
St. Clair	Pennington Stein, Acting	220 Fort Street Port Huron MI 48060	(810) 966-2000
St. Joseph	Chris Kadulski	692 E. Main St. Centreville MI 49032	(269) 467-1200
Sanilac	Irene Bazan Waller	515 S. Sandusky Rd. Sandusky MI 48471	(810) 648-4420

Schoolcraft	Robyn Loviska	300 Walnut St. Courthouse, Rm. 175A Manistique MI 49854	(906) 341-2114
Shiawassee	Susan Fulton	1975 W. Main, Suite 1 Owosso MI 48867	(989) 725-3200
Tuscola	Leonard Richards	1365 Cleaver Rd. Caro MI 48723	(989) 673-9100
VanBuren	Jerry Frank, Acting	57150 C. R. 681 Hartford MI 49057	(269) 621-2800
Washtenaw	Cynthia Travis	22 Center St. Ypsilanti MI 48198	(734) 481-2000
Wayne			
Adult Medical/ Services	Kay Andrzejak	27260 Plymouth Rd. Redford MI 48239	(313) 937-4200
Wexford	Dave VanHouten	10641 W. Watergate Rd. Cadillac MI 49601	(231) 779-4500

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